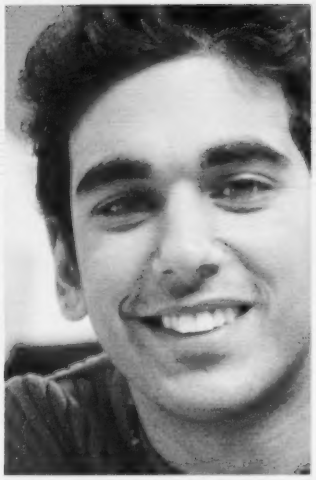

CIHI 2010–2011 Annual Report

The Difference Data Makes

Canadian Institute
for Health Information

Institut canadien
d'information sur la santé

Who We Are

Established in 1994, CIHI is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Funded by federal, provincial and territorial governments, we are guided by a Board of Directors made up of health leaders across the country.

Our Vision

To help improve Canada's health system and the well-being of Canadians by being a leading source of unbiased, credible and comparable information that will enable health leaders to make better-informed decisions.

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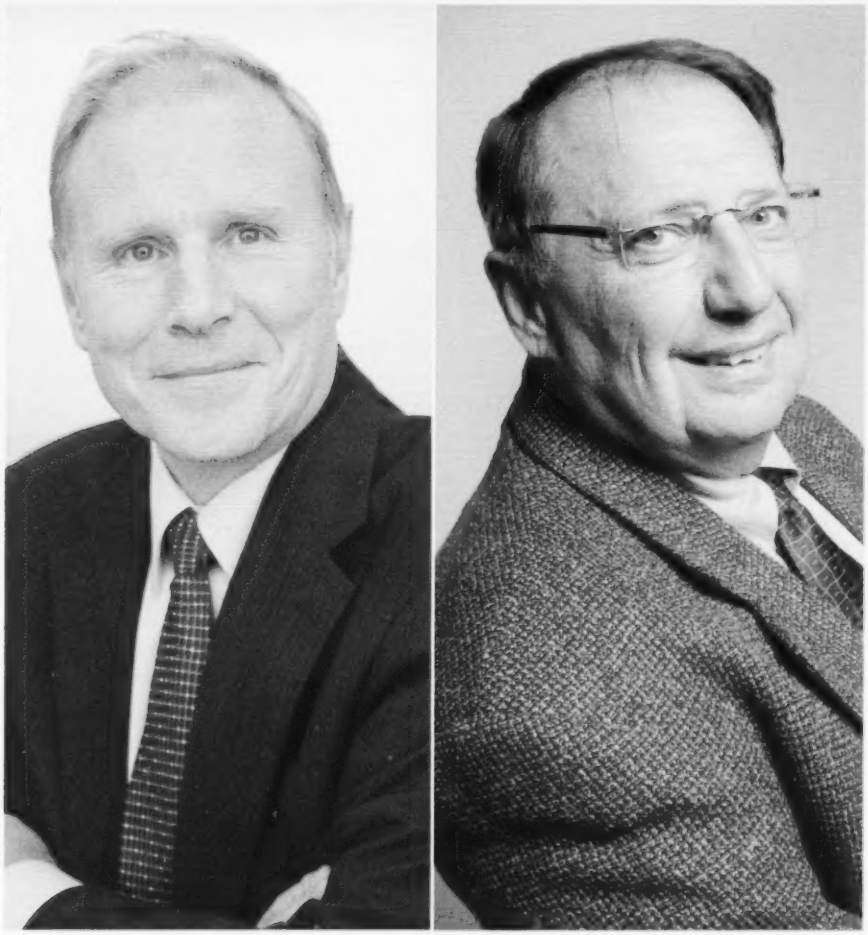


John Wright, President and CEO

Dr. Brian Postl, Board Chair

Message From the President and Board Chair

With governments across Canada battling deficits and concerns rising over health care spending, good, reliable data is more important than ever. Data has repeatedly shown that it's not always about spending more, it's about spending wisely. At CIHI, our mission is to provide policy-makers and health system managers with reliable, comparable information to make better health care decisions. By mining data and contrasting and comparing themselves with their peers, facilities and jurisdictions can assess their performance, learn from each other and make better use of existing resources. Beyond greater efficiencies, allowing data to drive decisions also leads to better, safer care.

Over the last year, we've increased jurisdictional participation in our 27 data holdings to better understand how care is delivered across the continuum. We've started important analytical work to shed new light on the major cost drivers of the past decade and to identify underlying trends that may affect future spending. We've also assisted jurisdictions with methodological support to explore new ways of funding the health care system, such as activity-based funding models.

Building on efforts to improve patient safety, we launched our new National System for Incident Reporting to track medication errors in acute care facilities. With the release of *Health Care in Canada 2010*, we started a conversation around appropriateness of care by looking at procedures that continue to be performed in the face of mounting evidence that they fail to improve patient outcomes. The report also showed that using the best available evidence to deliver, manage and measure care improves the overall efficiency of our system.

To support acute care efforts to improve care, we developed an innovative new performance measurement tool last year. The Canadian Hospital Reporting Project (CHRP) features 33 clinical and financial performance indicators that measure quality and efficiency in acute care hospitals. The goal is to provide comparative facility-level information that hospitals can use to identify areas for improvement. CHRP was supposed to begin as a small pilot project, but with jurisdictions wanting to participate in overwhelming numbers, we launched with more than 500 hospitals. This speaks to the incredible desire of our stakeholders to measure and monitor their performance, as well as the trust they put in us to gather reliable, high-quality data.

With initial funding from the Public Health Agency of Canada, we announced plans to develop a nationwide system to measure and monitor the evolution and treatment of multiple sclerosis. Working in close collaboration with the Multiple Sclerosis Society of Canada and the Canadian Network of Multiple Sclerosis Clinics, we want to provide new information to help improve the lives and care of the 55,000 to 75,000 Canadians living with this debilitating disease.

We continued to work with our partners to ensure new sources of data that can be useful and relevant for health system purposes and to fill important information gaps. Together with Canada Health Infoway, we're crafting a national vision for health system uses of electronic health records (EHRs) to focus planning and guide efforts in the development of EHR-based systems across Canada. System uses of health record data include tracking adverse events, monitoring patient outcomes and spotting trends. We've also developed and helped build support for common primary health care content standards in electronic medical records. The standards will allow primary

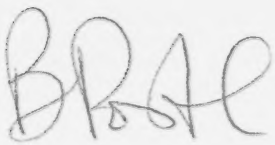
health care providers to collect information in a consistent fashion to better measure and monitor the quality of patient care in what is considered the front door of the health system.

We want to make sure we're as responsive as possible to the needs of health care decision-makers. This year, we developed a customer strategy to ensure our work remains relevant to the specific needs of our key stakeholders across the country—whether it means developing customized tools or providing help for small jurisdictions that lack the resources to do their own analysis.

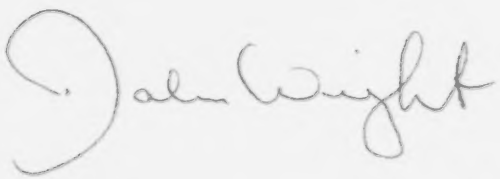
As a data-driven organization, it is more important than ever that our own working processes are as efficient and effective as possible, and that they are measurably so. Last year, KPMG carried out an independent evaluation and performance audit of the Health Information Initiative, our funding agreement with Health Canada. Overall, the results showed that the initiative's objectives were achieved. Also noted was our increasingly critical role in the coordination and delivery of trusted, high-quality information products to decision-makers, governments, hospitals and regions, to researchers and to Canadians all across Canada.

Our *Standards for Management Information Systems in Canadian Health Service Organizations* (MIS Standards) remain the gold standard among Canadian health service organizations for reporting financial and statistical information. They celebrated their 25th anniversary this year—and, like fine wines, they keep getting better with age!

There is plenty to be proud of, but there is still much work to be done. We're heading into the last year of our current four-year plan, and we'll be meeting with our stakeholders across the country as we chart a new course and ensure we continue to meet their needs. We're honoured to play a trusted role within the health care system, and we look forward to working with our pan-Canadian partners to take health information further in the coming year.



Dr. Brian Postl
Board Chair



John Wright
President and CEO

Our Accomplishments

Across the health system, data is relied on to measure performance, plan services, build business cases, identify best practices and, ultimately, improve the quality and efficiency of patient care. Together, these activities form a chain, linking data with decision-making and health outcomes. It follows that better data leads to better decisions—and we're committed to providing our stakeholders with the information they need to ensure that Canadians get the quality care they deserve.

Several years ago, we asked our health care partners across the country to identify their top information needs. Based on what we heard, we created a strategic plan with three directions to guide our work and focus our efforts, starting in 2008–2009 through to the end of March 2012, to meet those needs. These strategic directions are as follows:

1. **More and better data:** We will enhance the scope, quality and timeliness of our data holdings.

2. **Relevant and actionable analysis:** We will continue to produce quality information and analyses that are relevant and actionable.

3. **Improved understanding and use:** We will work with stakeholders to help them better understand and use our data and analyses; we will do this in a timely and privacy-sensitive manner.

As a data-focused organization, we believe it's important to be able to measure our progress. This is why our annual report includes a set of performance targets and measures that align with our corporate objectives and priorities. As we head into the last year of this strategic plan, you can see that we've met many targets, exceeded others and still have work to do in some areas.

More and Better Data

More and Better Data

Solid, reliable data is an asset for any organization. When your core business is health information, that importance is amplified. Decisions about the health care system are based on the information we glean from it—and that's a responsibility we take to heart. A clearer picture of our health care system allows health partners to understand what is working well and where improvements can be made. Among other things, data helps governments make decisions on resource allocation, regions and organizations redesign services and public health agencies decide where to target initiatives. As part of our strategic directions, we've made a commitment to our stakeholders to enhance the scope and quality of our databases. Here's what we achieved in the past year:

More Pharmaceutical Data

With the use of prescription drugs on the rise in Canada, good information is critical to the effective management of public drug programs and to the development of pharmaceutical-related policies. Our National Prescription Drug Utilization Information System (NPDUIS) Database allows health planners to compare how drugs are being used in their jurisdiction, how much they cost public programs and how pharmaceutical use is changing over time. This year, Ontario began submitting prescription drug claims data, bringing to seven the total number of provinces participating in the system, representing about 150 million records a year. As well, as part of a pilot project, the database now includes de-identified data from the First Nations and Inuit Health Branch at Health Canada.

Medication incidents are one of the most common adverse events in patient care, and the more we understand about them, the more we can do to prevent them. As part of our commitment to help our stakeholders improve patient safety and quality of care, on April 1, 2010, we launched the National System for Incident Reporting. Uptake has been significant, with new acute care facilities beginning to submit data on medication incidents. As part of a pilot project, 23 long-term care facilities have also begun submitting data, while the B.C. Patient Safety and Learning System will begin submitting provincial data on a trial basis. The addition of new jurisdictions will strengthen CIHI's capacity to support improvements in the safe delivery of health care across the country.

More Home and Continuing Care Data

With an aging population, understanding how care is delivered across the continuum is critical to the effective management of the health system as a whole. This past year, we saw a significant increase in the breadth of our long-term care data, with nearly 50% more facilities submitting to our Continuing Care Reporting System, for a total of approximately 1,100 facilities from 7 jurisdictions. That growth carried over to the Home Care Reporting System, which now has 30 regional organizations from 5 jurisdictions submitting data.

More Health Human Resources Data

Good information about the supply and cost of health professionals is essential for health planning purposes, to ensure Canadians continue to have access to the services they need in a timely fashion. To improve our understanding of how physicians are compensated, we've enhanced the National Physician Database to allow jurisdictions to submit physician-level alternative payment data. The goal is to integrate this with fee-for-service information to get a more complete picture of compensation at the physician level in Canada. New Brunswick, Prince Edward Island and Newfoundland and Labrador have been submitting alternative payment data for two years; this past year, British Columbia joined them.

We are currently in discussions with the Ordre des ergothérapeutes du Québec about its potential submission of record-level data to the Occupational Therapist Database beginning in 2011–2012. This would fill an important gap in our health human resources databases.

More Timely Costing and Ambulatory Care Data

Hospitals represent the largest category of health expenditure in Canada. With efforts to control spending across the system, our stakeholders have a growing interest in comparable acute care cost data. This past year, we enhanced our Canadian Management Information Systems (MIS) Database, the national data source for financial and statistical information about hospitals and health regions. The enhancements provide jurisdictions with access to more useful and timely data for analysis. In 2010–2011, hospital performance indicators were released five months earlier and, for the first time, we published a French version of the MIS Standards, making it easier for French data providers to collect and submit data.

Our National Ambulatory Care Reporting System, which holds data on emergency department (ED), day surgery and outpatient visits, continued to see jurisdictional uptake this year. This is mainly due to the introduction of a new level of ED reporting that reduces the burden of data collection and provides stakeholders with access to monthly ED Wait Times Reports within three weeks of month end.

Setting the Foundation for Better Primary Health Care Data

Primary health care (PHC) is the most common type of care experienced by Canadians, and it is widely recognized that more comprehensive care up front can lead to better health and fewer complications for patients down the road. We remain committed to strengthening PHC data and information in Canada, and we made important progress this year in securing support from jurisdictions for adopting common data standards for PHC electronic medical records (EMRs).

Our voluntary reporting system includes a subset of priority EMR data from more than 200 family physicians and 250,000 patients from across Canada. This data has allowed us to produce meaningful feedback reports and electronic quality improvement tools that PHC clinicians are using to improve their practices. We're also preparing to update the pan-Canadian PHC indicators in 2011.

Other Data Developments

Community Mental Health

To address data gaps in mental health—a priority area for CIHI—we've been working to identify and support new evaluation tools in community mental health. This past year, we released new sets of comparative reports highlighting community mental health pilot data from Ontario and Newfoundland and Labrador.

Aboriginal Health

Aboriginal health is another priority area for CIHI that has significant information gaps. We've been working with the First Nations and Inuit Health Branch at Health Canada on data development initiatives related to First Nations drug and home care data. We've also been working with Aboriginal organizations to develop analytical projects related to cardiac care (in partnership with Statistics Canada) and end-stage renal disease.

Data Quality Enhancements

We enhanced the quality of our data and information products through continued implementation of our comprehensive data quality program. We published a report showing significant improvement in the quality of data in the Discharge Abstract Database while continuing to produce data quality reports for deputy ministers. These reports provide useful information to jurisdictions to improve data quality. We also continued to engage with hospitals, jurisdictions and regional health authorities to help them address their data quality issues.

Health System Use of EHRs/EMRs

Information systems based on electronic health records or electronic medical records offer new opportunities to improve health system management and the health of Canadians. But to maximize the value of these systems, it is critical to examine how data from EHRs or EMRs can be used beyond the point of care. To that end, we've been working with Canada Health Infoway and jurisdictions to advance the health system use of data from EHRs. We've also worked on pan-Canadian standards, including PHC data content standards, and put together supporting documents in various policy areas.

Classifications

We completed a multi-year project to redevelop the Comprehensive Ambulatory Classification System grouping methodology. The new version, which will help give hospitals, researchers and governments an improved understanding of acute ambulatory care activity in Canada, was released on April 1, 2011.

More and Better Data Performance Measures

Increase Ambulatory Care/Emergency Department (ED) Data

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of sites/ facilities/jurisdictions submitting ED abstracts to NACRS (by reporting level: Level 1, Level 2 and/ or Level 3)	Maintain current percentage of ED abstracts reported Increase percentage of ED reporting to NACRS across Canada (all reporting levels) from 38% to 53% Add 100% of Alberta ED day surgery and clinic activity	Percentage of ED reporting to NACRS across Canada is 53% (includes full Alberta reporting) New Nova Scotia facility started submitting day surgery abstracts to NACRS

Increase Home Care Data

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of jurisdictions participating in HCRS	Six jurisdictions participating in HCRS (increase of one jurisdiction)	Five jurisdictions participating
Number of regional health authorities/ local health integration networks (RHAs/LHINs) submitting RAI-HC data to HCRS	40 RHAs/LHINs submitting RAI-HC data (increase of 10 RHAs/LHINs)	30 RHAs/LHINs submitting RAI-HC data

Increase Continuing Care Data

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of jurisdictions participating in CCRS	Seven jurisdictions participating in CCRS (increase of one jurisdiction)	Seven jurisdictions participating
Number of facilities/ long-term care (LTC) homes submitting RAI-MDS 2.0© data to CCRS	1,050 facilities/LTC homes submitting RAI-MDS 2.0 data (increase from 839 facilities)	1,062 submitting organizations

Increase Pharmaceutical Data

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of jurisdictions submitting data to the NPDUIS Database	One new jurisdiction submitting data to the NPDUIS Database	Two new jurisdictions submitting data to the NPDUIS Database: Ontario and First Nations and Inuit Health Branch

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More and Better Data Performance Measures (cont'd)

Increase Medication Incident Reporting		
Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of facilities submitting data to NSIR	25% increase (total of 20 facilities)	25 new facilities submitting data (total of 41 facilities)

Increased Implementation of PHC Information Program		
Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Develop pan-Canadian PHC Electronic Medical Record Content Standards (PHC EMR CS)	Release new pan-Canadian PHC EMR CS and implementation guides by March 2011	Three products that comprise the PHC EMR CS project were made available on CIHI's website in April 2011
Increase data collected for the PHC Voluntary Reporting System (number of sites participating in the PHC Voluntary Reporting System)	EMR data for 200,000 Canadians from 200 PHC clinicians by March 2011	EMR data for more than 270,000 unique patients received from 221 physicians in nine sites in Ontario, B.C. and Manitoba in 2010–2011
Produce new actionable information on PHC	Produce three Analysis in Brief (AiB) reports on PHC	One AiB released

Improve Quality and Comprehensiveness of Patient-Specific Cost Data		
Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of sites submitting patient-specific cost data to CIHI	Six new sites (total of 45 sites)	45 sites

Note

Nellie Semple, Resident, Willow Lodge Home for Special Care

Data Helps Battle Depression

At Willow Lodge Home for Special Care in Nova Scotia, staff had always felt their residents were happy and content.

But when the Tatamagouche nursing home started using quality indicators as part of a provincial pilot project, that thinking was stopped in its tracks.

"Our rates of depression were over 50%," says Betty Matheson, Willow's Director of Nursing. "And at that time, the instance of little or no patient participation in activities was about the same. That was a real eye-opener for us."

To assess the well-being of her residents, Matheson used measurement tools developed by interRAI, an international research collaborative, and supported for use in Canada by CIHI.

The tools allow her to monitor not just how individual patients are doing but how her nursing home is doing as a whole, compared with other long-term care facilities, using evidence-based quality of care indicators.

Matheson and her team examined residents' medications and their activities. She says they changed their approach to patient care by looking at the resident as an individual with specific needs. They overhauled the home's activity program to better reflect the interests of the lodge's 61 residents.

"If they're happy watching their soaps, you might think they're just sitting in their room, that they're not involved," Matheson says. "But if that's what they've watched every day for the last 50 years, that's certainly an activity for them."

Residents are now doing more than ever before, with a range of activities to chose from, such as music, dancing, card games and pet therapy.

"For years we had no one who liked to bake. Now we have a lady who bakes every day," she says. "She's just having a great time. We also have a lot of people who now enjoy bingo."

Not surprisingly, depression rates at the home have dropped by half.

"Depression is something we watch very closely," Matheson says. "It's a major thing among the elderly. They can start to spiral downwards very quickly."

Without the data and the quality indicators, however, she says they never would have known what they were dealing with. Today, staff receives data in real time.

"It's wonderful. You can instantly see how you're doing and compare yourself at different times," Matheson says. "Our staff is always keen on anything that will benefit the residents, and first and foremost, I'm a caregiver. If I didn't see a benefit for my residents, I wouldn't be doing it. But the data doesn't lie."

Relevant and Actionable Analysis

Relevant and Actionable Analysis

Over the last year, we continued to increase the overall depth and breadth of analysis and reporting across our data holdings, releasing more than 34 analytical products.

Our stakeholders have told us they want relevant measures of health system performance, more timely information on emerging health care issues, better information to address health disparities and a better understanding of how we spend our health care dollars. Here's what we accomplished this year to meet the priority information needs of our stakeholders:

Performance Measurement

Given the substantial jurisdictional interest in measuring and comparing hospital performance, we produced our first electronic pan-Canadian hospital performance reports this past year. The reports are based on 33 comparable indicators in areas such as clinical effectiveness, patient safety and financial performance, and they allow facilities to compare themselves with their peers. The reporting tool was released to 574 acute care hospitals in 10 jurisdictions for validation and testing purposes, and a public release is expected in 2012.

We're also working with our partners to improve measurement in priority areas, such as cardiac care. This past year, we worked with cardiac centres in British Columbia and Ontario on a pilot project to identify facility-level quality indicators based on existing data sources. A preliminary data release to participating centres included 14 indicators.

Emerging Issues and Access to Care

To assist with future pandemic planning, we released *The Impact of the H1N1 Pandemic on Canadian Hospitals*, which looked at how the health care system coped with the surge of influenza cases at the height of H1N1. The report examined the number of patients hospitalized, the specialized care they required, the estimated cost of treatment and how H1N1 hospitalizations differed from those for seasonal influenza.

Thanks to more comparable wait time information, we published national indicators on how long Canadians are waiting for care in priority areas, compared with medically recommended benchmarks, in *Wait Times in Canada—A Comparison by Province, 2011.* Building on this, we continued to work with the provinces to develop wait time indicators for ED and specialist care. We also launched a four-year feasibility study to follow dialysis patients to gain new insight on access to and waits for kidney transplants.

Factors Affecting Health

We continued to push ahead on the Canadian Population Health Initiative Action Plan, which was developed to inform policies that reduce inequities and improve the health and well-being of Canadians. It focuses on the factors that contribute to healthy weights, the determinants of mental health and resilience, the links between place and health, and reducing gaps in health.

As part of the plan, we released a report on urban physical environments and health inequalities. It showed that Canadians who live in the poorest areas were the most likely to face the effects of air pollution and heat extremes and provided an in-depth review of relevant policies and interventions.

Health Care Costs

Health care spending remains an important topic of debate in Canada and a key issue for policy-makers. This past year, we undertook a major analytical project on health care cost drivers in Canada. The project will shed new light on the major cost drivers of the past decade and identify underlying pan-Canadian trends that may affect future health spending. Preliminary findings of the various analyses were shared with ministry of health representatives, including expenditure trends at the macro-economic, physician, drug, hospital and other types of health care levels. A final summary report will be made public in the fall.

There has been a move toward activity-based funding in many provinces, which calls for more specific information on the cost of and payment for specific health services. To that end, we established a unit to help jurisdictions use our case mix grouping methodologies with this type of funding. This unit will serve as a centre of technical expertise on the design, implementation, monitoring and evaluation of health care funding models. In Ontario, CIHI is working with the Ministry of Health and Long-Term Care to help stakeholders with the deployment and use of the Health Based Allocation Model (HBAM), which is designed to promote cost-effective delivery of care. We also provided significant support to the British Columbia Ministry of Health Services in its patient-focused funding activities and to Alberta Health Services' design and implementation of an activity-based funding system for acute care.

High-Impact CIHI Studies Released in 2010–2011

- *Health Care in Canada 2010* sparked a conversation across Canada about potentially inappropriate care and the importance of using evidence to deliver better health care. The report featured new analysis of potentially inappropriate surgical procedures and variations in surgical care, including information on the potential costs of excess surgical procedures. The report was released alongside hospital standardized mortality ratio results, which highlighted progress made by Canadian acute care facilities in reducing mortality rates.
- Our annual physician and nursing workforce reports, *Supply, Distribution and Migration of Physicians, 2009* and *Regulated Nurses: Canadian Trends, 2005 to 2009*, found significant growth in the supply of these important health providers in Canada. In 2009, the number of physicians reached an all-time high, with an annual increase of 4%, or three times the growth of the Canadian population. The nursing workforce also grew faster than the population, with a 9% increase over five years; however, the ratio of nurses to the population in Canada is still lower than it was in the early 1990s.
- This year's *Health Indicators 2010* report included a special analysis on socio-economic disparities. It found that while lower-income Canadians were more likely to have heart attacks, the quality of care for heart attack patients was about the same for all Canadians. It also found that health differences among regions were often greater than those among income levels, and that reducing these disparities could generate important savings for the system. The report included more than 40 measures of health and health system performance by health region and province or territory.
- Chronic conditions, not age, are the major driver of health system use among seniors. Our analysis, *Seniors and the Health Care System: What Is the Impact of Multiple Chronic Conditions?*, found that seniors age 85 and older with no chronic conditions made less than half the number of health care visits as younger seniors (age 65 to 74) with three or more chronic conditions. The study examined how seniors living in the community access health services and the care they receive.

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High-Impact CIHI Studies Released in 2010–2011

(cont'd)

- *National Health Expenditure Trends, 1975 to 2010* is Canada's most comprehensive annual report on health spending by province, source of finance and category of spending. This year's report showed that while health care spending continued to rise in 2010, it is estimated to have reached its lowest growth rate in a decade, with health spending as a percentage of gross domestic product dropping slightly.
- In 2010, we released two topical reports related to care for seniors in the community. *Supporting Informal Caregivers—The Heart of Home Care* found that one in six informal caregivers was suffering from distress and identified risk factors most commonly associated with distress. *Caring for Seniors With Alzheimer's Disease and Other Forms of Dementia* found that, in 2007–2008, one in five seniors (20%) receiving long-term home care had a diagnosis of Alzheimer's disease or other dementia—some with relatively high levels of impairment.

Top 10 Products in Media Coverage

1	*National Health Expenditure Trends, 1975 to 2010*
2	*Supply, Distribution and Migration of Canadian Physicians, 2009*
3	*Health Care in Canada 2010* and HSMR 2010 results
4	*Supporting Informal Caregivers—The Heart of Home Care* and *Caring for Seniors With Alzheimer's Disease and Other Forms of Dementia*
5	*Regulated Nurses: Canadian Trends, 2005 to 2009*
6	*Drug Expenditure in Canada, 1985 to 2009*
7	*Wait Times in Canada—A Comparison by Province, 2011*
8	*Health Indicators 2010*
9	*The Impact of the H1N1 Pandemic on Canadian Hospitals*
10	*Depression Among Seniors in Residential Care*

More Relevant and Actionable Analysis

Increase Overall Depth, Breadth and Relevance of Analytical Products

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of regular annual reports produced	18 regular annual reports produced	23 regular annual reports produced in 2010–2011
Number of special/ topical reports produced	Six special/topical reports produced	Two special reports produced in 2010–2011
Number of AiBs produced	14 AiBs produced	Nine AiBs produced in 2010–2011
Percentage of stakeholders rating CIHI analytical products as being relevant (based on biennial stakeholder survey)	90%	N/A (biennial survey not conducted this year)
Percentage of stakeholders rating CIHI analytical products as being actionable (based on biennial stakeholder survey)	80%	N/A (biennial survey not conducted this year)

Develop New Comparative Health Indicators

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of health indicators produced	Three new indicators will be developed for mental health (30-day mental illness readmission rate, self-injury hospitalization rate and repeat hospitalizations for mental illness)	Three new mental health indicators developed; feedback received and updates made to methodology Indicators finalized for 2011 publication

Develop Pan-Canadian Hospital Performance Reports

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of jurisdictions included in pan-Canadian reports	Addition of 1 jurisdiction (total of 10)	10 jurisdictions
Number of users/ sites included in pan-Canadian reports	250 users representing 560 sites	742 registered users representing 572 sites

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More Relevant and Actionable Analysis (cont'd)

Develop New eReporting Tools/Reports

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of eReporting products built and delivered for program areas to launch to CIHI clients	Four new eReporting products to be built and delivered for program areas to launch to CIHI clients	Four new eReporting products built as of year end: • Canadian Hospital Data Preview eReporting Product • Quick Stats Community eReports • eNACRS eReporting Product • Canadian Hospital Reports e-Tool

Increase Adoption/Uptake of CIHI Portal

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of participating sites	19 new sites (total of 65)	121 sites
Number of clients	224 new clients (total of 460)	351 new clients

Increase Number of Data Offerings in CIHI Portal

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of data marts available in CIHI Portal	One new data mart (total of four)	NRS data mart added (total of four)

Increase Overall Reach and Impact of CIHI Data and Information Products

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Percentage of stakeholders rating CIHI as an essential source of information	85% (82% in 2009 client survey)	N/A (biennial survey not conducted this year)
Percentage of stakeholders rating CIHI as a trusted source of information	90% (86% in 2009 client survey)	
Percentage of stakeholders rating CIHI as adding value to their organizations	85% (83% in 2009 client survey)	
Measures of reach and impact to be developed in concert with launch of new website	TBD	Under development

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More Relevant and Actionable Analysis (cont'd)

Increase Number and Reach of Educational Offerings

Performance Measures	Targets for 2010–2011 (as of March 31, 2011)	2010–2011 (as of March 31, 2011)
Number of face-to-face educational workshops offered	145 face-to-face workshops offered	132 face-to-face workshops offered
Number of registrations (for all education offerings)	Approximately 24,000 registrations	24,270 registrations

Dayle Maryniak, Manager, Pleasant View Care Home

Data Helps Put Philosophy Into Practice

In the Saskatoon Health Region, data has been credited with helping to turn a philosophical shift into practical changes on the front lines of care.

Although a least restraint use policy had been introduced in 2004, quality indicators showed that at Pleasant View Care Home in Wadena, more than 50% of residents were being physically restrained on a daily basis in 2005. Facility manager Dayle Maryniak remembers being taken aback.

"It was terrible," she says. "The restraints weren't ever meanness on the part of staff. It was their attempt to keep their clients safe. But because you get used to looking at the people you care for every day, until numbers indicate to you what is actually happening and you stop and look, it was just the business we did every day."

The indicators were developed by interRAI, an international research collaborative, and supported for use in Canada by CIHI. They allowed Maryniak to assess individual residents and compare her nursing home to other long-term care facilities.

The indicators also showed that while some homes were doing well, nearly half of all nursing homes in the region were exceeding the daily restraint use threshold of 8.7% of residents. A decade ago anyone prone to fall or wander was restrained. But a shift in care approaches meant that was no longer acceptable. With so many risks associated with restraints, Sherri Solar, Supportive Care Projects Coordinator for the region, says they worked to ensure that people looked at all alternatives before using them.

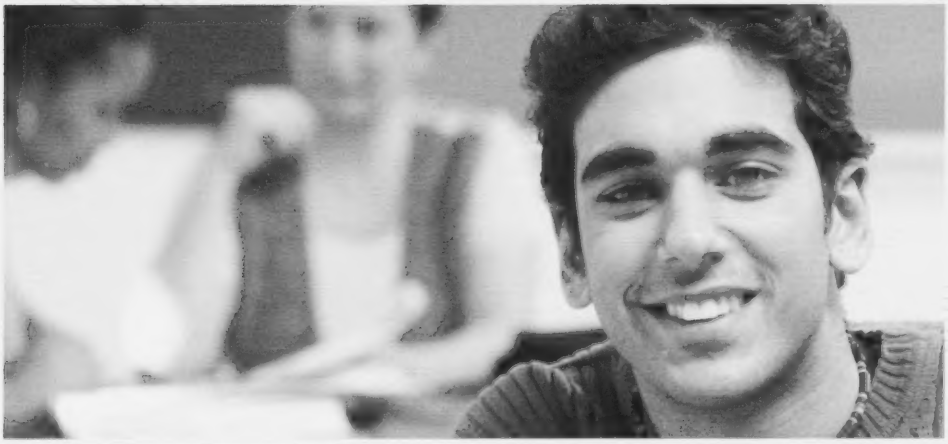
"We took two individual clients to start with and asked ourselves, 'If we take away the restraints, what options are there?'" Maryniak recalls. "That started a whole journey of education and interaction with staff and clients to apply that to other residents."

Restraint use has dropped 20% across the region and 40% at Pleasant View, despite an increase in dementia and frailty cases among residents. Today, use is short term and never a unilateral decision. Care teams and family members are involved.

"It's phenomenal. Culture change is happening," says Solar. "But I don't think we could have done this without looking at the data."

Maryniak says while residents are visibly happier, the lack of screaming and anguished noises, as well as staff complaints of bites, punches and kicks, which were commonplace even six years ago, has driven home what they've accomplished.

"It's been a worthwhile journey. Staff and clients have benefited immensely from it."



Improved Understanding and Use

Improved Understanding and Use

Our clients and key stakeholders are responsible for running a system that operates 24 hours a day, 7 days a week, 365 days a year. Decisions are constantly being made—and having sound and timely information to base them on is of the utmost importance. For this reason, we are committed to providing our stakeholders with both reliable data and the tools and resources they need to understand and use it.

We've worked hard to enhance our overall responsiveness by taking a more strategic approach to reaching out to our stakeholders. We've created a comprehensive education strategy to focus and refine what we're offering to our clients. This past year, CIHI delivered 132 face-to-face workshops to customers across the country. Other initiatives to increase understanding and use of our products and services include the following:

CIHI Portal

CIHI Portal provides facilities and jurisdictions with access to pan-Canadian data for analyses around decision support, performance management and improvement. We continue to enhance CIHI Portal for our customers, and this past year we integrated inpatient rehabilitation services data from the National Rehabilitation Reporting System (NRS) and added the ability for our users to include income-related information in their customized reports.

CIHI Portal uptake increased significantly this past year to include 351 users at 121 sites in 9 jurisdictions across the country. We've also been working with the Canadian Association of Paediatric Health Centres to support a pilot project with pediatric hospitals in Quebec, and another that will add community hospitals to this same community of practice. This project represents the first time Quebec clients have accessed data from the Discharge Abstract Database using Portal.

eReporting and New Website

To improve the accessibility and timeliness of our information, we've been developing more electronic reporting tools for our customers. This includes an eReporting tool that will enable health human resources (HHR) data to be disseminated in a timelier, more standardized, interactive and user-friendly format; the release of this format is tentatively scheduled to take place in 2012–2013. We expect this will eventually replace some of the narrative HHR annual reports.

Providing a more user-friendly experience was one of the many reasons we launched a new website last November. Based on customer research and best practices, the site is more intuitive and improves access to the many data and information products housed online.

Collaborative Work

Our regional offices do a great job of identifying opportunities to align our data and products to address regional needs. We also work with jurisdictions and organizations to enhance data flow, uptake of databases and interjurisdictional comparisons, and to reduce the duplication of work. This year those efforts included the following:

- The development of a data disclosure agreement with Cancer Care Ontario (CCO) will see Ontario dialysis data come directly from CCO instead of from individual facilities. This follows the Ontario Ministry of Health and Long-Term Care's mandate to CCO to implement, operate and manage a renal network in the province.
- A data access agreement is in development to give the Canadian Agency for Drugs and Technologies in Health access to NPDUIS Database formulary data.
- A British Columbia data sharing agreement was finalized that governs the collection and disclosure of data by CIHI. A data sharing agreement was also reached with Statistics Canada.
- Working with the Atlantic Collaborative on Health Information, a preliminary plan was prepared to better understand alternate level of care patients in Atlantic Canada.
- We are helping the Capital District Health Authority (CDHA) in Nova Scotia implement case costing. In addition to completing a readiness assessment and providing planning advice, our staff have been actively working with CDHA executives to identify creative ways to expedite the project.
- Along with the Ontario Ministry of Health and Long-Term Care, the Ontario Hospital Association, the local health integration networks and the Ontario Health Quality Council, we're working to reduce duplication and provide uniformity in the methods and definitions of performance indicators used by public reporting agencies.
- We are developing memoranda of understanding with other national organizations that are working on priority themes, such as quality and safety. These include Accreditation Canada and the Canadian Patient Safety Institute.

Overview of National Data Collection (March 31, 2011)

Service Type	Data Holdings	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	N.L.	Y.T.	N.W.T.	Nun.
Acute and Ambulatory Care	Inpatient (DAD/HMDB)						1							
	Day Surgery (DAD/NACRS)		✔				1							
	Emergency Department (NACRS)	✔	✔	✔								✔		
	Ambulatory Clinics (NACRS)		✔											
Continuing and Specialized Care	Inpatient Mental Health (HMHDB)						✔							
	Rehabilitation (NRS)													
	Continuing Care (CCRS)		✔			✔								
	Home Care (HCRS)	✔	✔		✔									
	Organ Registry (CORR)							2		2 ✔	2		2	
	Trauma (NTR-MDS)													
	Joint Replacement (CJRR)													
Pharma-ceuticals	Pharmaceutical Use (NPDUIS)					✔								
	Incident Reporting (NSIR)			✔		✔			✔					✔
Health Human Resources	Physicians (NPDB)													
	Regulated Nurses (4) (NDB)													
	Health Providers (HPDB)													
	Occupational Therapists (OTDB)													
	Pharmacists (PDB)													
	Physiotherapists (PTDB)								✔					
	Medical Radiation Technicians (MRTDB)													
	Mecial Laboratory Technicians (MLTDB)													
Health Spending	National Expenditures (NHEX)													
	Hospital Sector (CMDB)						3							

Legend

✔ Denotes progress in data collection efforts as compared with previous fiscal year.

- Complete Data Collection
- Partial Data Collection
- Data Submission Plans Being Developed
- In Discussion
- Not Implemented
- Not Applicable

Notes

(1) Quebec submits data to the HMDB.
(2) Renal dialysis has been fully implemented; organ transplant is not applicable.
(3) Quebec submits data using a different standard. CIHI is working toward including Quebec data in future indicator reports.
(4) Includes databases of registered nurses, licensed practical nurses and registered psychiatric nurses.

Events and Conferences Sponsored or Hosted by CIHI

Last year saw us host several national and international conferences to promote increased understanding and use of our data and information products. In September, we co-hosted the Data Users Conference 2010 in Ottawa, which attracted more than 300 attendees from across Canada. The program included a keynote address from Dr. Nick Black of the United Kingdom, who provided a historical background of the collection of health outcomes data, highlighted the barriers and challenges to moving the health outcomes agenda forward and introduced the white paper recently tabled by the U.K. government that cements its endorsement of health outcomes data collection.

In October, we co-hosted the World Health Organization Family of International Classifications Network Annual Meeting 2010 in Toronto. With the theme Data Makes a Difference, it was the largest event in its history, with approximately 200 attendees from 30 countries taking part. We shared hosting duties with the U.S. National Center for Health Statistics and Statistics Canada.

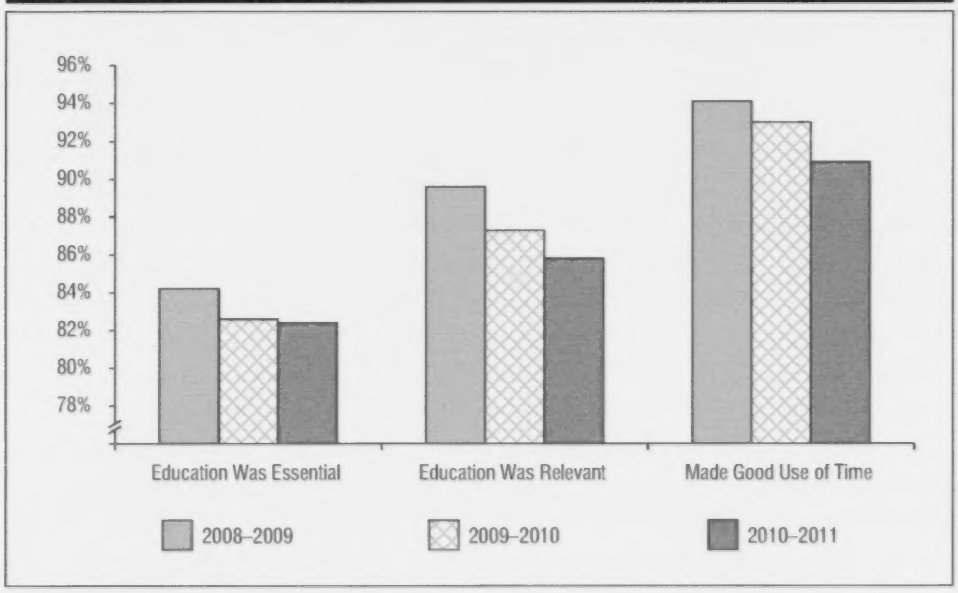
Allocating health system funding is one of the key challenges facing senior health care decision-makers as they deal with increased pressures to improve health system quality, access and efficiencies while controlling costs. With jurisdictions looking at new methods to allocate funding and variations on standard methods, in November we partnered with the Institute of Health Economics to bring key decision-makers together to foster informed debate on funding options, issues and associated implications.

Outreach

Our people presented at the following events and organizations:

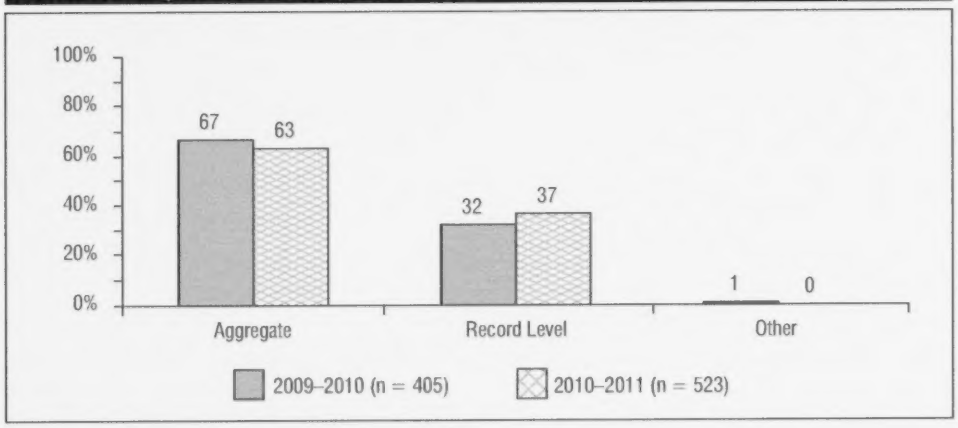
- eHealth Think Tank
- Western Health Care CEOs
- National Health Care Leadership Conference
- Manitoba Centre for Health Policy
- Association québécoise des archivistes médicales
- eHealth 2010
- Health Care Leaders Association of British Columbia
- OHA Health Achieve 2010
- Institute for Clinical Evaluative Sciences Health Care 2011
- 2011 Cochrane Canada 9th Annual Symposium
- 2011 CEO Forum
- Funding Models to Support Quality and Sustainability: A Pan-Canadian Dialogue
- Health System Performance Seminar
- Canadian Dental Association's Committee on Clinical and Scientific Affairs
- Partnership in Productivity Colloquium
- 2010 Canadian Science Policy Conference
- 2010 Ontario Education Research Symposium

Education Session Evaluation

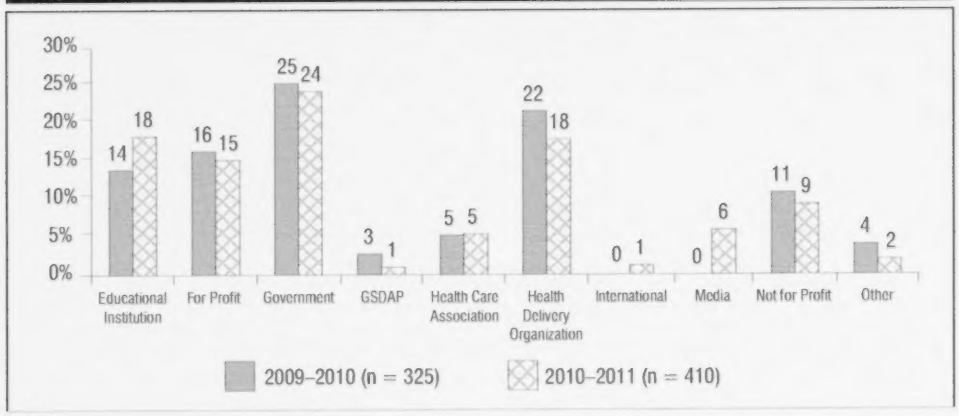


Data Requests

Nature of Requested Data, by Fiscal Year

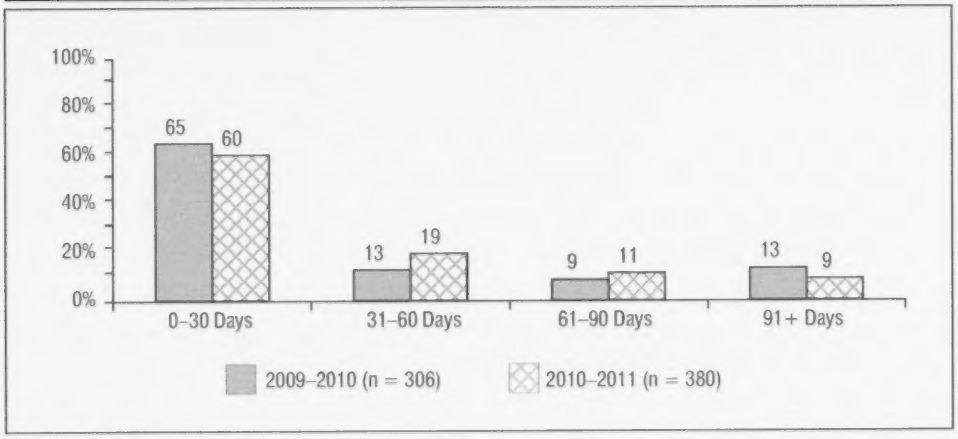


Requestor Organization Type, by Fiscal Year (Third Party Requests Only)



Note
GSDAP: Graduate Student Data Access Program.

Completed Requests, by Turnaround Time



Media Coverage

Fiscal Year	Print Mentions	Broadcast Mentions	Web Mentions	Total Mentions	Total Circulation (Millions)	Total Solicited Mentions Only
2008–2009	882	364	951	2,197	210.2	1,308
2009–2010	941	520	1,493	2,954	502.1	2,052
2010–2011	506	776	1,230	2,512	228.0	2,057

Data Privacy and Security

No matter what we're working on, we remain committed to protecting the privacy of Canadians and ensuring the security of their personal health information. Being entrusted with data that deals with sensitive information is a responsibility we take seriously.

We have a comprehensive privacy and security program to protect our data holdings, governed by an overarching privacy and security framework. The framework is based on best practices for privacy and information management from across the public, private and health sectors. It includes a robust set of policies, procedures and protocols around both privacy and information security.

We are a prescribed entity under Ontario's *Personal Health Information Protection Act, 2004*. This allows health information custodians in Ontario, such as the Ministry of Health and Long-Term Care, hospitals and physicians, to disclose personal health information to us without patient consent for analysis or to compile statistical information for the planning and management of the health system. This designation and the strict responsibilities that come with it give our data partners across the country assurance that our privacy and security policies comply with the highest standards in safeguarding important and sensitive information. The information and privacy commissioner of Ontario reviews our practices and procedures every three years, and we are currently working on our submission for the renewal of our prescribed entity status in October 2011.

We conduct regular privacy audits within and outside the organization to monitor compliance with legislative or regulatory requirements, internal policies and any other contractual obligations pertaining to privacy and security. This past year, we implemented changes to further strengthen our privacy audit program and to improve the accountability of organizations who receive de-identified data under our third-party data request process.

Our Organization

We know we are nothing without our talented and dedicated staff. The successes captured on these pages all lead back to their efforts. Over the last year, we've developed and implemented additional strategies to support the recruitment, development and retention of a skilled workforce. We were also recognized by *Maclean's* magazine as one of Canada's top 25 campus employers.

Independent Evaluation and Performance Audit

Last year, KPMG carried out an independent evaluation and performance audit of the Health Information Initiative, which is our funding agreement with Health Canada. The results of this review were very positive. Overall, the evaluation showed that the initiative's objectives were achieved and that we have been successful in realizing its mandate while playing an increasingly critical role in the coordination and delivery of trusted, high-quality information products to decision-makers, governments, hospitals, regions, researchers and Canadians all across Canada.

The performance audit showed that we have designed and implemented efficient and economical practices and processes. It found we were effective in meeting the initiative's objectives and achieving the expected results. A number of positive practices were highlighted, including our privacy program, data quality management, information security, engagement of stakeholders, process improvements and communications.

The reports also identified some areas for improvement, which we are already addressing.

Among the recommendations was one to develop an overarching stakeholder management framework in conjunction with our customer strategy. We agree with this and are folding a more strategic approach to stakeholder engagement into our customer strategy, which is in development. We expect to have this implemented by January 2012.

As well, it was recommended that we revise our performance measurement framework to include more outcome-based measures and focus on critical performance measures in a dashboard approach. Prior to receiving the auditor's report, our executive team had already agreed to review our performance measurement framework and indicators. We want to create a focused framework that reflects our future goals, as well as a core set of indicators and outcome measures. Plans are in place to present this to the Board of Directors in November 2011.

Jim Hornell, President and CEO, BCHS

Kathy Stauffer, Board Chair, BCHS

Data Helps Promote a Culture of Safety

While other facilities in southern Ontario have battled some significant infection outbreaks, to date, Brantford General Hospital has managed to avoid them.

"It seems like we've been an island of cleanliness," says Jim Hornell, President and CEO of Brant Community Healthcare System (BCHS). "That's more than just luck. It's because we've invested in handwashing."

Patient safety has been a corporate priority at BCHS since 2007. But the impetus for change dates back to 2003, when the SARS outbreak killed 44 people in Ontario.

"SARS changed everything," says Kathy Stauffer, BCHS Board Chair. "We'd been reactive. But when you're dealing with people's lives, you have to be proactive. You don't want people coming into the hospital to get sick. This is a place where you're supposed to get better."

Led by Lynn Vogt, Manager of Risk, Quality, Patient Safety and Patient Relations, Brantford developed a comprehensive three-year plan to eliminate the risk of infection in the hospital. Significant investment was made in handwashing, and there was a shift to "no blame, no shame" around adverse events, which saw reporting increase 540%.

To track its patient safety efforts, the hospital began paying close attention to its hospital standardized mortality ratio (HSMR). Developed for use in Canada by CIHI, it allows hospitals to assess their mortality rates and identify areas for improvement.

In addition to hiring two infectious disease specialists, Brantford created a decision-support team to mine data, research trends and help teams identify good practice and where they need to change. To address medication errors, the hospital launched a medication reconciliation plan and introduced a new computerized bedside medication verification system—the first in Canada. It also opened a new, fully automated lab—another Canadian first. Throughout this process, CIHI's HSMR has been front and centre on a corporate scorecard of quality and safety indicators. Vogt says it's their baseline.

"It's your big-dot indicator on really, how safe is your hospital? You certainly want to know how safe are you overall and how do you measure compared to others."

Brantford's efforts are paying off. In just three years, its mortality ratio has dropped more than 40%. In 2010, the hospital had the lowest HSMR in Canada.

"The numbers don't lie," Stauffer says. "If you can't measure it and you can't monitor it, you can't manage it. The data drives these initiatives. It is imperative to your success."

Looking Ahead

Looking Ahead

The coming year is a critical juncture for us, as it marks the final year of our four-year strategic directions plan and our five-year funding agreement with Health Canada. We've been hard at work developing an approach and action plan for renewing our long-range strategic plan and funding. We continue to talk to our clients and key stakeholders about their critical health information priorities and what we can do to meet them. In addition, client surveys, our independent evaluation and performance audit, and targeted stakeholder consultations are helping to guide us as we shape our future path.

The coming year contains a mix of new and continuing activities. This work represents our ongoing desire to improve the depth and breadth of our health care data; produce analyses that are relevant, timely and actionable for our clients; and increase the understanding and use of our data and methods in Canada through a range of tools and strategies. As approved by our Board, these key initiatives include the following:

More and Better Data

- Increase jurisdictional uptake of selected reporting systems, with a continued focus on home and continuing care, pharmaceuticals, medication incidents and emergency visits.
- Continue to develop and implement our PHC information program.
- Work to address information gaps in the areas of Aboriginal health and community mental health.
- Collaborate with jurisdictions and Canada Health Infoway to advance health system use of data and the pan-Canadian agenda related to EHRs and EMRs.

More Relevant and Actionable Analysis

- Publicly release CHRP results and continue to make enhancements.
- Implement a rolling multi-year analytical plan and release reports and special studies focused on access to care, patient outcomes, continuity of care, cancer, cost drivers, productivity and seniors.
- Complete the implementation of the Canadian Population Health Initiative Action Plan.

Understanding and Use

- Continue to support the adoption and uptake of CIHI Portal and enhance/expand client access to eReports.
- Continue to enhance our newly launched website.
- Implement the newly developed customer strategy.
- Seek renewal of our status as a prescribed entity under Ontario's *Personal Health Information Protection Act* and implement follow-up recommendations from the information and privacy commissioner of Ontario.

To support priority initiatives along our three strategic themes, a sound corporate infrastructure is required. As a result, we will continue to focus on enhancing our corporate processes, IT systems applications and electronic tools.

It follows that we will also complete the development of our new strategic plan (beyond 2011–2012) and renew our funding agreements with both Health Canada and the provincial/territorial ministries in support of our new strategic directions.

Management Discussion and Analysis

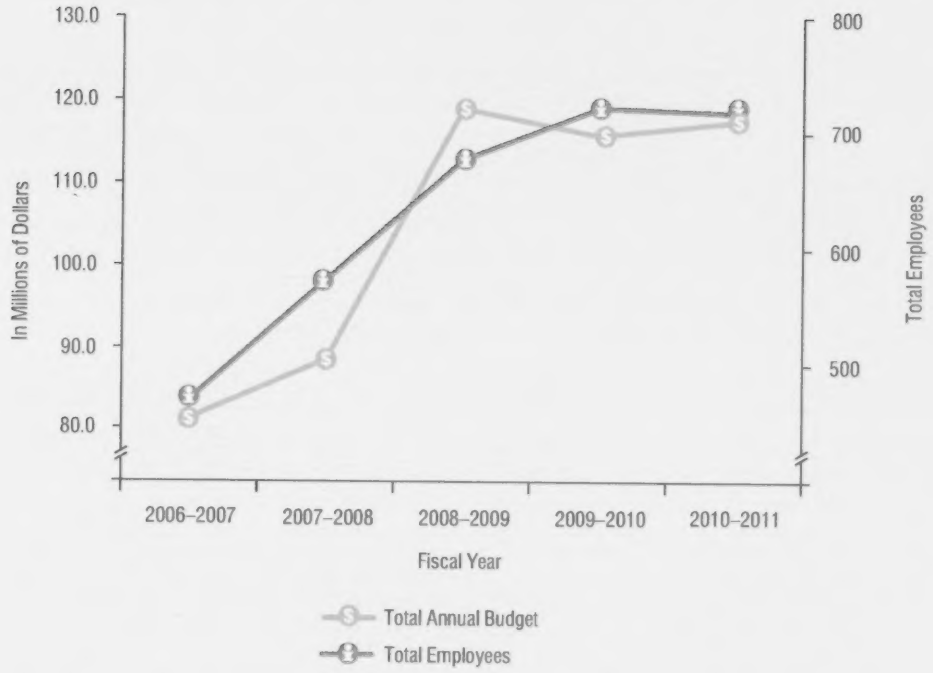
Management Discussion and Analysis

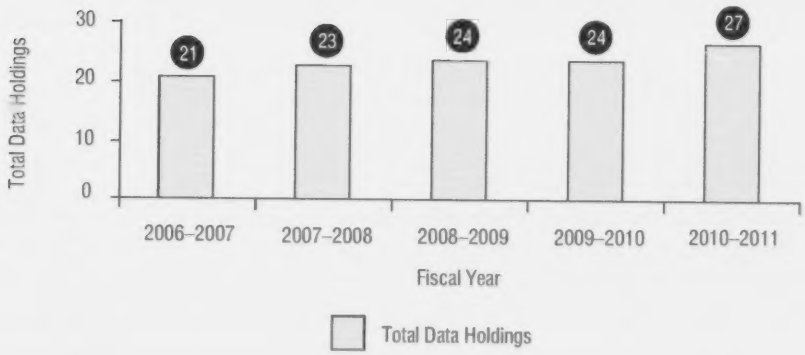
The following section provides an overview of our operations and an explanation of our financial results; it should be read in conjunction with the financial statements contained in this annual report. In accordance with Canadian generally accepted accounting principles, the preparation of the financial statements as well as the integrity and objectivity of the data in these financial statements are management's responsibility. In support of our responsibility, we design and maintain systems of internal controls to provide reasonable assurance that the financial information is reliable and available on a timely basis, that the assets are safeguarded and that the operations are carried out effectively.

The Board of Directors is responsible for ensuring that management fulfills its responsibility for financial reporting and internal controls; it exercises this responsibility through the Finance and Audit Committee (FAC), which is composed of directors who are not employees of the organization. The external auditors, Ernst & Young LLP, conduct an independent audit in accordance with Canadian generally accepted auditing standards and express an opinion on the financial statements. The external auditors meet on a regular basis with management and the FAC. They have full and open access to the FAC, with or without the presence of management. The FAC reviews the financial statements and recommends their approval by the Board of Directors. For 2010–2011 and previous years, the external auditors have issued unqualified opinions.

In recent years, our organization has gradually transitioned from an environment of rapid and significant growth to one of stability and consolidation. Our total annual budget, consisting of our operating and capital resources requirements, as well as the financing of our pension plans, has reached a financial level slightly higher than $115 million. We now have close to 750 employees, and we house 27 data holdings.

Total Budget, Employees and Data Holdings





Our ongoing programs and new initiatives are managed within the terms and conditions of our federal, provincial and territorial agreements, which provide the majority of our annual total revenue.

Annual Source of Revenue ($ Millions)	2011–2012	2010–2011		2009–2010	2008–2009	2007–2008
	Planned	Actual	Planned	Actual	Actual	Actual
Federal Government	97.0	98.5	97.0	92.3	104.5	66.2
Provincial/Territorial Governments	18.9	18.4	17.7	17.3	16.8	16.6
Other	2.2	2.1	2.1	1.8	2.9	3.7
Total Annual Source of Revenue	118.1	119.0	116.8	111.4	124.2	86.5

The relative revenue contributions of the federal government, the provincial/territorial governments and other sources have been somewhat constant over the last few years (in 2010–2011, the proportions were 83%, 15% and 2%, respectively). Since 1999, Health Canada has significantly funded, through a series of grants and contribution agreements referred to as the Roadmap Initiative or Health Information Initiative, the building of a comprehensive national health information system and infrastructure to provide Canadians with the information they need to maintain and improve Canada's health system and the population's health. As well, the provincial/territorial ministries of health have funded our Core Plan through bilateral agreements.

Management Explanation of Results

Operating Expenses

Operating Expenses ($ Millions)	2011–2012	2010–2011		2009–2010	2008–2009	2007–2008
	Planned	Actual	Planned	Actual	Actual	Actual
Salaries and Benefits	73.9	71.9	71.1	64.4	61.2	50.4
Professional Services, Travel and Advisory Committee Expenses	15.0	17.4	18.9	20.3	30.4	21.7
Occupancy, Information Technology and Other	18.4	17.8	18.8	17.6	17.5	11.4
Total Operating Expenses	107.3	107.1	108.8	102.3	109.1	83.5

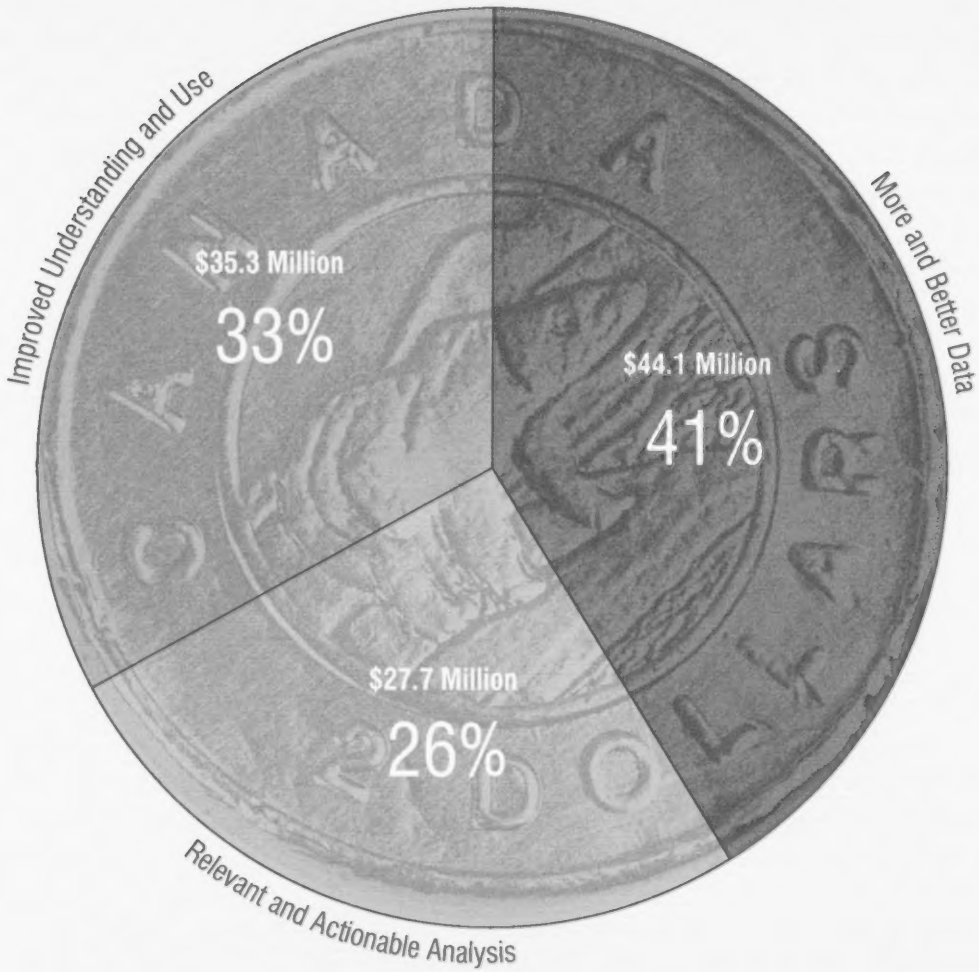
Our total operating expenses in 2010–2011 were $107.1 million, an increase of $4.8 million over 2009–2010. This increase is largely attributable to increased costs associated with salaries and benefits, reflecting the hiring of additional resources to support our program of work, as well as higher costs for pension benefits. Total remuneration, including any fee allowance or other benefits to our senior management team that are listed in this annual report for the continuous accomplishment of the strategic directions, represented $4.9 million for 2010–2011.

The total expenditure variance of $1.7 million relative to the planned 2010–2011 activities relates mainly to cost efficiencies realized in non-salary and benefits expenses, as well as a collective effort to better manage our resources and a redirection of resources to fund our pension plan actuarial deficits.

Prior years' results reflected the growth of the organization. Professional services, travel and advisory committee expenses included several one-time activities relating to external expertise required during the period of growth, specific contributions toward population health research studies and special projects, and the Canadian Health Measures Survey conducted by Statistics Canada.

Similar to 2008–2009 and 2009–2010, our investments in the three strategic directions—*more and better data*, *relevant and actionable analysis* and *improved understanding and use*—remained relatively constant as a proportion of the total operating actual and planned expenses.

2010–2011 Operating Expenses, by Strategic Direction



Total: $107.1 million; 100%

Capital Investments

Capital Investments ($ Millions)	2011–2012	2010–2011		2009–2010	2008–2009	2007–2008
	Planned	Actual	Planned	Actual	Actual	Actual
Furniture and Office Equipment	0.1	0.2	0.2	0.1	2.1	0.4
Computers and Telecommunications Equipment	2.3	1.5	2.5	3.0	6.2	3.0
Leasehold Improvements		0.3	0.1	0.2	7.3	0.2
Total Capital Investments	2.4	2.0	2.8	3.3	15.6	3.6

Acquisition of capital assets for 2010–2011 amounted to $2.0 million, a decrease of $1.3 million from 2009–2010. This variance relates mainly to reduced purchases of computer hardware, software and telecommunications-related equipment.

The variance of $0.8 million against the planned 2010–2011 activities reflects a revised and diminished work plan in the area of information and technology infrastructure.

Prior years' results included the renewal of our technology infrastructure, as well as new one-time requirements such as the relocation of our Toronto office and expansion of offices in Ottawa and Montreal, telephone system and web content, and business management software and hardware.

Pension Plans

We sponsor a contributory defined-benefit plan that offers our employees annual retirement income based on length of service and final average earnings. Contributions are determined by actuarial calculations and depend on employee demographics, turnover, mortality, investment returns and other actuarial assumptions. CIHI and employee contributions are invested in pooled funds and professionally managed in accordance with the Statement of Investment Policies and Procedures.

There are two valuations prepared for the plan: one for accounting purposes (see note 8 of the financial statements) and one for funding purposes, which is used for regulatory purposes and management of the plan. The valuations for accounting and funding purposes are prepared at different times and use different assumptions. Based on accounting standards prescribed by the Canadian Institute of Chartered Accountants, on March 31, 2011, the plan reported a surplus of $9.9 million, compared to $3.8 million in 2009–2010. On a funding basis, the plan had a deficit of $4.7 million on January 1, 2010, compared with a deficit of $2.1 million on January 1, 2009.

The past few years' economic turmoil had a significant impact on the plan's funding valuation. Management and the FAC continue to monitor the economic environment and are taking the necessary steps to address the unfunded liability. Particularly, in 2010–2011, we made changes to our investment managers and investment policies and also contributed $2.25 million in excess of the minimum regulatory requirements toward the actuarial deficits. An actuarial valuation as of January 1, 2011, and a plan design review are currently under way.

In addition to the contributory defined benefits plan, we supplement the benefits of employees participating in the plan who are affected by the application of the *Income Tax Act*'s maximum pension limit. The supplementary plan is not pre-funded, and we make benefit payments as they become due. These benefits are accrued and recognized in our financial statements in accordance with applicable accounting rules.

Internal Audit Program

Our internal audit program provides independent, non-biased assurance to add value to and improve our operations. It helps us accomplish our objectives by bringing a systematic, disciplined approach that both evaluates and improves the effectiveness of risk management, control and governance processes. Our internal audit program includes evaluating compliance with administrative policies, procedures and government regulations; assessing the overall effectiveness of controls and processes currently in place; and identifying opportunities for improvement and efficiencies.

The internal audit activities vary in scope and evolve over time to focus on areas of greatest risk to the organization. In 2010–2011, activities included information technology hardware and systems testing and vulnerability assessment, in addition to Health Canada's mandatory performance audit and evaluation (previously discussed). Targeted action plans were developed to address the areas for improvement that were recommended by the consultants contracted by us to perform these activities. Upcoming internal audit projects include activities in the area of risk management, information security and privacy and confidentiality.

Risk Management

At CIHI, we're not averse to taking risks—we just want to make sure they're reasonable, manageable and based on risk tolerance. Our approach is to be proactive and mitigate risks where we can. CIHI's risk management program ensures management excellence, strengthened accountability and improved future performance. It also supports planning and priority-setting, resource allocation and decision-making. We focus on risks that cut across the organization, are linked to our strategic directions, are likely to remain for the next three to five years and can be managed by our senior leadership.

Our Risk Management Framework consists of the following four processes, which are geared toward achieving CIHI's strategic directions:

Risk Management Activities

This past year, our senior management team assessed a number of key risks that could prevent us from achieving our strategic directions, based on their likelihood of occurrence and their potential impacts. Three of these were identified as corporate risks, due to their high level of residual risk (risk level after considering existing mitigation strategies).

Electronic Health Record/Electronic Medical Record

The implementation of EHRs/EMRs across Canada represents both an opportunity and a potential risk for us in terms of data collection activities for health system analyses. We have continued in our leadership role by working with Canada Health Infoway and the jurisdictions to ensure that new EHR/EMR systems consider all opportunities and risks for all uses of the data, including health system analysis.

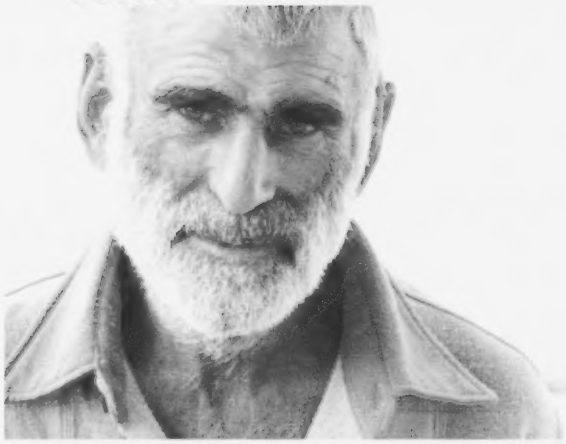
These efforts have been endorsed by the Conference of Deputy Ministers of Health and have included the development of a communication and engagement strategy; a long-term vision of benefits for health system use of health information in Canada; pan-Canadian standards, such as primary health care data content standards; and other supporting documents in various policy areas.

Data Flows/Gaps, Including Competitive Databases

There is always a risk that the need for or value of our products could decrease because of information gaps caused by a lack of participation in pan-Canadian databases. However, by working closely with our stakeholders, we've been successful in expanding national uptake in the Home Care Reporting System, Primary Health Care Voluntary Reporting System, Continuing Care Reporting System, National System for Incident Reporting, National Rehabilitation Reporting System and eReports. As a result of the launch of the new NRS data, use of CIHI Portal increased significantly this year. We also succeeded in expanding jurisdictional submission of claims data to the NPDUIS Database and gained increased access to physician billing data at the patient record level. We also forged a partnership with Ontario's Ministry of Health and Long-Term Care to support the effective deployment and use of HBAM.

Sustained Funding Levels

We receive funding from several sources, with the majority of our funding coming from Health Canada. Given the current economic climate and competing fiscal priorities for governments, sustained funding is at risk. In the past year, we've actively promoted our role and value to the health care system. Strong collaborative relationships have been established between our CEO and senior officials from our founding partners. We will be renewing funding agreements with provincial/territorial ministries of health and have started discussions with Health Canada for renewal of a long-term funding agreement effective April 2012. We were also successful in securing resources for new initiatives, including HBAM for Ontario and the Canadian Multiple Sclerosis Monitoring System.



Audited Financial Statements

Independent Auditor's Report

To the Board of Directors of the Canadian Institute for Health Information

We have audited the accompanying financial statements of the Canadian Institute for Health Information (CIHI), which comprise the balance sheet as at March 31, 2011 and the statements of revenue and expenses, changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of CIHI as at March 31, 2011 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Ottawa, Canada,
June 3, 2011

Ernst & Young LLP

Chartered Accountants
Licensed Public Accountants

Balance Sheet

As at March 31

	2011 $	2010 $
Assets		
Current:		
Cash and cash equivalents *(note 3)*	**9,415,915**	18,924,509
Accounts receivable *(note 4)*	**3,273,336**	1,515,540
Prepaid expenses	**2,289,373**	2,197,725
	14,978,624	22,637,774
Investments—Roadmap *(note 5)*	**9,778,466**	15,475,008
Capital assets *(note 6)*	**17,610,241**	20,500,547
Other assets *(note 7)*	**478,889**	401,187
Accrued pension benefit asset *(note 8)*	**9,863,900**	3,846,500
	52,710,120	62,861,016
Liabilities		
Current:		
Accounts payable and accrued liabilities *(note 10)*	**5,616,554**	10,818,763
Unearned revenue	**5,500,567**	5,910,541
	11,117,121	16,729,304
Accrued pension benefit liability *(note 8)*	**556,600**	498,700
Deferred contributions *(note 11)*		
Expenses of future periods	**18,808,292**	20,393,230
Capital assets	**14,507,704**	17,174,550
Lease inducements *(note 12)*	**2,651,433**	3,120,262
	47,641,150	57,916,046
Commitments *(note 16)*		
Net Assets		
Invested in capital assets	**2,115,955**	2,115,133
Unrestricted	**2,953,015**	2,829,837
	5,068,970	4,944,970
	52,710,120	62,861,016

See accompanying notes.

On behalf of the Board

Director

Director

Statement of Revenue and Expenses

Year ended March 31

	2011 $	2010 $
Revenue		
Core Plan *(note 13)*	**16,368,700**	15,891,245
Sales	**1,769,190**	1,628,308
Funding—other *(note 14)*	**2,873,562**	3,375,388
Health Information Initiative/Roadmap	**86,075,097**	81,399,875
Other revenue	**160,052**	177,824
	107,246,601	102,472,640
Expenses		
Compensation	**71,939,221**	64,406,138
External and professional services	**13,229,836**	15,543,288
Travel and advisory committee expenses	**4,194,783**	4,717,000
Office supplies and services	**1,448,429**	1,600,780
Computers and telecommunications	**7,338,178**	7,206,292
Occupancy	**8,972,154**	8,793,142
	107,122,601	102,266,640
Excess of revenue over expenses	**124,000**	206,000

See accompanying notes.

Statement of Changes in Net Assets

Year ended March 31

	Invested in capital assets	Unrestricted	2011	2010
	$	$	$	$
Balance, beginning of year	**2,115,133**	**2,829,837**	**4,944,970**	4,738,970
Excess (deficiency) of revenue over expenses	**(693,982)**	**817,982**	**124,000**	206,000
Net investment in capital assets	**694,804**	**(694,804)**	**—**	—
Balance, end of year	**2,115,955**	**2,953,015**	**5,068,970**	4,944,970

See accompanying notes.

Statement of Cash Flows

Year ended March 31

	2011 $	2010 $
Operating Activities		
Excess of revenue over expenses	**124,000**	206,000
Items not affecting cash:		
Amortization of capital assets	**4,660,147**	4,693,028
Amortization of lease inducements	**(468,829)**	(479,910)
Pension benefits	**(5,959,500)**	(5,815,300)
Amortization of deferred contributions—capital assets	**(3,927,471)**	(3,860,979)
Loss on disposal of capital assets	**185,588**	66,792
	(5,386,065)	(5,190,369)
Changes in non-cash working capital items *(note 15)*	**(7,461,627)**	4,640,620
Net change in other assets	**(77,702)**	(96,691)
Net change in deferred contributions	**(324,313)**	1,692,740
Cash provided by (used in) operating activities	**(13,249,707)**	1,046,300
Investing Activities		
Acquisition of capital assets	**(1,960,186)**	(3,301,037)
Proceeds on disposal of capital assets	**4,757**	8,280
Acquisition of investments—Roadmap	**(23,940,090)**	(62,850)
Proceeds on disposal of investments—Roadmap	**29,636,632**	9,063,554
Cash provided by investing activities	**3,741,113**	5,707,947
Net cash (outflow) inflow	**(9,508,594)**	6,754,247
Cash and cash equivalents, beginning of year	**18,924,509**	12,170,262
Cash and cash equivalents, end of year	**9,415,915**	18,924,509
Represented by:		
Cash	**1,915,915**	2,924,509
Short-term investments	**7,500,000**	16,000,000
	9,415,915	18,924,509
Supplementary information		
Interest received	**191,120**	112,763
Interest paid	**—**	—

See accompanying notes.

Notes to Financial Statements

March 31, 2011

1. Organization

The Canadian Institute for Health Information (CIHI) is a national not-for-profit organization incorporated under Part II of the *Canada Corporations Act*.

CIHI's mandate is to serve as the national mechanism to coordinate the development and maintenance of a comprehensive and integrated approach to health information for Canada. It also provides and coordinates the provision of accurate and timely data and information required for the establishment of sound health policy; the effective management of the Canadian health system; and generating public awareness about factors affecting good health.

CIHI is not subject to income taxes.

2. Accounting Policies

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

The following are the significant accounting policies:

Revenue Recognition

CIHI follows the deferral method of accounting.

Funding contributions are recognized as revenue in the same period as the related expenses are incurred. Amounts approved but not received at the end of the period are recorded as accounts receivable. Excess contributions which require repayment in accordance with the agreement are recorded as accrued liabilities.

Contributions provided for a specific purpose and those restricted by a contractual arrangement are recorded as deferred contributions, and subsequently recognized as revenue in the same period as the related expenses are incurred.

Contributions provided for the purchase of capital assets are recorded as deferred contributions—capital assets, and subsequently recognized as revenue over the same terms and on the same basis as the amortization of the related capital assets.

Interest revenue is recorded as period income on the basis of the accrual method.

Restricted investment revenue and investment losses on restricted contributions are debited or credited to the related deferred contributions account and recognized as revenue in the same period as eligible expenses are incurred.

Investments—Roadmap

Investments—Roadmap are recorded at fair value determined based on quoted market value of the underlying investments or the unit values of the pooled funds as supplied by the investment manager.

Capital Assets

Capital assets are recorded at cost and are amortized on a straight-line basis over their estimated useful lives as follows:

Computers	5 years
Furniture and equipment	5–10 years
Telecommunication equipment	5 years
Leasehold improvements	Term of lease

Lease Inducements

Lease inducements, consisting of leasehold improvement allowances, free rent and other inducements, are amortized on a straight-line basis over the term of the lease.

Pension Benefits

The actuarial determination of the accrued benefit obligations for pensions uses the projected benefit method prorated on service which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors.

For the purpose of calculating the expected return on plan assets, those assets are valued at fair value.

Actuarial gains or losses arise from the difference between actual long-term rate of return on plan assets for a period and the expected long-term rate of return on plan assets for that period or from changes in actuarial assumptions used to determine the accrued benefit obligation. The excess of the net accumulated actuarial gain or loss over 10 percent of the greater of the benefit obligation and the fair value of plan assets is amortized over the average remaining service period of active employees. The average remaining

service period of the active employees covered by the registered pension plan is 13 years (2010—13 years). The average remaining service period of the active employees covered by the supplementary retirement plan is 12 years (2010—12 years).

Foreign Currency Translation

Revenue and expenses are translated at the exchange rates prevailing on the transaction date. Any resulting foreign exchange gains or losses are charged to miscellaneous income or expenses. Foreign currency monetary assets and liabilities are translated at the prevailing rates of exchange at the balance sheet date.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from management's estimates as additional information becomes available in the future.

The estimated useful lives of capital assets and the amount of accrued liabilities, including the accrued pension benefits, are the most significant items where estimates are used.

Financial Instruments

Financial instruments are measured at fair value on initial recognition. Subsequent to initial recognition, they are accounted for based on their classification. Cash and cash equivalents as well as investments are designated as held-for-trading and are measured at fair value. Accounts receivable net of allowance for doubtful accounts are designated as loans and receivables and are carried at amortized cost. Accounts payable and accrued liabilities are classified as other financial liabilities and carried at amortized cost. Because of the short-term nature of the accounts receivable as well as the accounts payable and accrued liabilities, amortized cost approximates fair value.

It is management's opinion that CIHI is not exposed to significant interest rate or credit risks arising from the financial instruments.

a) Interest Rate Risk

Interest rate risk refers to the adverse consequences of interest rate changes on CIHI's cash flows, financial position and investment income.

b) Credit Risk

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss.

Credit risk concentration exists where a significant portion of the portfolio is invested in securities which have similar characteristics or similar variations relating to economic, political or other conditions. CIHI monitors the financial health of its investments on an ongoing basis.

Capital Management

CIHI's objectives when managing capital is to safeguard its ability to continue as an independant not-for-profit organization in an effort to carry out its mandate. Through various contribution agreements, the federal, provincial and territorial ministries of health provide most of CIHI's capital resources. The Investments—Roadmap, restricted by the Health Information Initiative agreement with the federal Ministry of Health, is another source of capital. CIHI manages its related programs and projects within the terms and conditions of these agreements, including the requirement to fund its retirement benefits plans in accordance with related regulations. CIHI's management monitors its capital by reviewing periodically various financial metrics, including cash flow and variances to budget and multi-year forecasts. CIHI has complied with all of its externally imposed restrictions.

In addition, as disclosed in note 9, CIHI has an available line of credit that is used when sufficient cash flow is not available from operations to cover operating and capital expenditures.

3. Cash and Cash Equivalents

Cash and cash equivalents are comprised of cash and short-term investments with a variety of interest rates and having original maturity dates of less than 90 days (2010—90 days).

4. Accounts Receivable

	2011	2010
	$	$
Operating	**1,457,319**	1,038,596
Funding—other	**1,816,017**	476,944
	3,273,336	1,515,540

5. Investments—Roadmap

The Investments—Roadmap consist of financial instruments, such as GICs and term deposits. For the comparative period, the investments were held in low-risk financial instruments pooled funds.

6. Capital Assets

	2011		2010	
	Cost	Accumulated Amortization	Cost	Accumulated Amortization
	$	$	$	$
Computers	**19,001,611**	**12,054,825**	18,463,358	10,101,852
Furniture and equipment	**6,146,335**	**3,106,575**	6,833,163	3,374,665
Telecommunication equipment	**1,349,627**	**818,376**	1,640,645	931,756
Leasehold improvements	**10,694,875**	**3,602,431**	10,597,909	2,626,255
	37,192,448	**19,582,207**	37,535,075	17,034,528
Accumulated amortization	**(19,582,207)**		(17,034,528)	
Net book value	**17,610,241**		20,500,547	

7. Other Assets

Other assets consist of rent deposits to landlords for office space as well as prepaid software, equipment support and maintenance expenses.

8. Accrued Pension Benefits

CIHI has a contributory defined benefit plan (Registered Retirement Plan) which offers its employees annual retirement income based on length of service and highest consecutive five-year average earnings. In addition, CIHI supplements this benefit to plan members who are affected by the application of the *Income Tax Act's* maximum pension limit (Supplementary Retirement Plan).

The most recent actuarial valuation for funding purposes of the Registered Retirement Plan was prepared by Mercer, a firm of consulting actuaries, as of January 1, 2010. The next valuation will be as of January 1, 2011.

The fair value of the plans' assets and accrued benefit obligations for accounting purposes are determined by Mercer as at March 31 of each year.

The following tables present the plans' funded status and amounts recognized in CIHI's balance sheet.

The pension plans' expenses include the following components:

	2011		2010	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Current service cost, net of employee contributions	**4,409,800**	**50,000**	1,333,200	30,000
Interest cost on accrued benefit obligation	**2,889,400**	**26,000**	1,963,500	24,700
Expected return on plan assets	**(2,981,300)**	**—**	(1,985,800)	—
Amortization of transitional asset	**(57,700)**	**—**	(57,700)	—
Amortization of net actuarial loss (gain)	**23,500**	**(6,600)**	(429,300)	(18,000)
Pension plan expense	**4,283,700**	**69,400**	823,900	36,700

The transitional asset was $923,357 as at April 1, 2000.

Changes in the accrued benefit obligation are as follows:

	2011		2010	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit, obligation beginning of year	**41,221,300**	**354,700**	20,395,400	275,000
Current service cost, net of employee contributions	**4,409,800**	**50,000**	1,333,200	30,000
Interest cost on accrued benefit obligation	**2,889,400**	**26,000**	1,963,500	24,700
Employee contributions	**2,745,600**	**—**	2,327,000	—
Benefits paid	**(1,065,300)**	**(11,500)**	(1,539,500)	(89,400)
Actuarial gain	**2,833,700**	**40,900**	16,741,700	114,400
Accrued benefit obligation, end of year	**53,034,500**	**460,100**	41,221,300	354,700

Changes in the plan assets are as follows:

	2011		2010	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Fair value of assets, beginning of year	**41,153,300**	**—**	27,583,100	—
Actual return on assets	**4,152,700**	**—**	6,196,200	—
Employer contributions	**10,301,100**	**11,500**	6,586,500	89,400
Employee contributions	**2,745,600**	**—**	2,327,000	—
Benefits paid	**(1,065,300)**	**(11,500)**	(1,539,500)	(89,400)
Fair value of assets, end of year	**57,287,400**	**—**	41,153,300	—

The plans' assets consist of:

	2011		2010	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	%	%	%	%
Asset category:				
Bonds	**35**	**—**	35	—
Equities	**65**	**—**	65	—
	100	**—**	100	—

CIHI recorded the assets and liabilities as follows:

	2011		2010	
	Registered Retirement Plan	Supplementary Retirement Plan	Registered Retirement Plan	Supplementary Retirement Plan
	$	$	$	$
Accrued benefit obligation, end of year	**(53,034,500)**	**(460,100)**	(41,221,300)	(354,700)
Fair value of assets, end of year	**57,287,400**	**—**	41,153,300	—
Funded status—surplus (deficit), end of year	**4,252,900**	**(460,100)**	(68,000)	(354,700)
Unamortized transitional asset	**(288,600)**	**—**	(346,300)	—
Unamortized net actuarial loss (gain)	**5,899,600**	**(96,500)**	4,260,800	(144,000)
Accrued pension benefit asset (liability)	**9,863,900**	**(556,600)**	3,846,500	(498,700)

The actuarial assumptions, which represent management's best estimate assumptions used to determine costs and benefit obligations, were as follows:

	2011		2010	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Service cost for years ended March 31:				
Discount rate	**6.50**	**6.50**	9.00	9.00
Expected long-term rate of return on assets	**6.75**	**—**	6.75	—
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00
Accrued benefit obligation as of March 31:				
Discount rate	**6.25**	**6.25**	6.50	6.50
Rate of compensation increase	**4.00**	**4.00**	4.00	4.00

9. Bank Indebtedness

CIHI has a line of credit of $500,000 with a financial institution bearing interest at prime rate. This credit facility is secured by a general security agreement on all assets with the exception of information systems. As at March 31, 2011, a letter of credit of $230,500 (March 31, 2010—$240,600) for the purpose of the Supplementary Retirement Plan had been issued against the line of credit.

10. Accounts Payable and Accrued Liabilities

Accounts payable and accrued liabilities are operational in nature. At the end of the year, no amount (2010—$2,530,082) representing the excess contribution received from Health Canada for the Health Information Initiative is payable.

11. Deferred Contributions

Expenses of Future Periods

Since 1999, Health Canada has been significantly funding, through the Roadmap Initiative, the building of a comprehensive national health information system and infrastructure to provide Canadians with the information they need to maintain and improve Canada's health system and the population's health. Health Canada's funding contributions were received in the form of global direct payments. The ongoing funding of the Roadmap Initiative along with other funding contributions from Health Canada was

consolidated through the Health Information Initiative as of April 1, 2007. Health Canada's funding contribution is received annually based on CIHI's capital resources requirements.

Deferred contributions related to expenses of future periods represent unspent restricted contributions. The changes for the year in the deferred contributions—expenses of future periods are as follows:

	2011 $	2010 $
Balance, beginning of year	**20,393,230**	21,300,252
Current year contribution received from Health Canada	**81,746,294**	81,745,999
Contribution repayable to Health Canada	**—**	(2,530,082)
Restricted investment revenue	**77,019**	15,719
Amount recognized as funding—CIHI operations	**(82,147,626)**	(76,129,818)
Amount recognized as funding—CPHI	**—**	(1,409,078)
Amount transferred to deferred contributions—capital assets	**(1,260,625)**	(2,599,762)
Balance, end of year	**18,808,292**	20,393,230

Capital Assets

Deferred contributions related to capital assets include the unamortized portions of restricted contributions with which capital assets were purchased.

The changes for the year in the deferred contributions—capital assets balance are as follows:

	2011 $	2010 $
Balance, beginning of year	**17,174,550**	18,435,767
Amount received from Health Information Initiative contribution	**1,260,625**	2,599,762
Amount recognized as funding	**(3,927,471)**	(3,860,979)
Balance, end of year	**14,507,704**	17,174,550

12. Lease Inducements

The lease inducements include the following amounts:

	2011	2010
	$	$
Leasehold improvement allowances	**986,582**	1,210,864
Free rent and other inducements	**1,664,851**	1,909,398
	2,651,433	3,120,262

The amortization of leasehold improvement allowances and free rent and other inducements are $224,282 and $244,547, respectively (2010—$234,226 and $245,684, respectively).

13. Core Plan

The Core Plan revenue relates to a set of health information products and services offered to Canadian healthcare facilities, regional health authorities and provincial/territorial ministries of health. Provincial/territorial governments have secured CIHI Core Plan on behalf of all facilities in their jurisdiction.

14. Funding—Other

	2011	2010
	$	$
Provincial/territorial governments	**2,070,743**	1,362,068
Federal government	**630,796**	2,008,545
Other	**172,023**	4,775
	2,873,562	3,375,388

15. Net Change In Non-Cash Working Capital Items

	2011	2010
	$	$
Accounts receivable	**(1,757,796)**	1,438,053
Prepaid expenses	**(91,648)**	(342,321)
Accounts payable and accrued liabilities	**(5,202,209)**	316,705
Unearned revenue	**(409,974)**	3,228,183
	(7,461,627)	4,640,620

16. Commitments

The CIHI leases office space under different operating leases, which expire on various dates. In addition, CIHI is committed under various agreements with respect to professional contracts and software and equipment maintenance and support. The minimum amounts payable over the next five years and thereafter are as follows:

	$
2012	12,273,325
2013	9,027,005
2014	8,717,922
2015	8,610,648
2016 and thereafter	17,678,436

17. Comparative Financial Statements

The comparative financial statements have been reclassified from statements previously presented to conform to the presentation of the current year financial statements.

Our Leadership and Governance

Senior Management (as of March 31, 2011)

John Wright
President and CEO

Jean-Marie Berthelot
Vice President, Programs

Jack Bingham (left April 2011)*
Executive Director, Ontario

Anne McFarlane
Vice President, Western Canada and Developmental Initiatives

Scott Murray
Vice President and Chief Technology Officer

Louise Ogilvie
Vice President, Corporate Services

Stephen O'Reilly
Executive Director, Atlantic Canada

Jeremy Veillard (started May 2010)
Vice President, Research and Analysis

Elizabeth Blunden
Director, Human Resources and Administration

Lorraine Cayer
Director, Finance

David Clements (started September 2010)
Director, Corporate Planning and Accountability

Anne Cochrane
Director, Corporate Communications and Outreach

Cathy Davis
Acting Director, Acute and Ambulatory Care Information Services

Brent Diverty (on secondment as of December 2010)
Director, Continuing and Specialized Care Information Systems

Mark Fuller
Director, Architecture, Planning and Standards

Jean Harvey
Director, Canadian Population Health Initiative

Kimberly Harvey
Director, Applications and Web Services

Michael Hunt
Director, Pharmaceuticals and Health Workforce Information Services

Kira Leeb
Director, Health System Performance

Mimi Lepage
Chief Privacy Officer and General Counsel

Kathleen Morris
Director, Health System Analysis and Emerging Issues

Mea Renahan (as of February 2011)
Director, Clinical Data Standards and Quality

Francine Anne Roy
Director, Health Spending and Strategic Initiatives

Greg Webster
Director, Primary Health Care Information and Clinical Registries

Douglas Yeo
Director, Continuing and Specialized Care Information Systems

André Lalonde (left October 2010)*
Executive Director, Corporate Planning and Quality Management

Louis Barré (left March 2011)
Vice President, Strategy, Planning and Outreach

Indra Pulcins (left March 2011)
Director, Indicators and Performance Measurement

* Jack Bingham retired from CIHI on April 21, 2011, and André Lalonde retired on October 15, 2010. We would like to thank Jack and André for their many years of dedicated service to the organization and for their sage advice.

Board of Directors (as of March 31, 2011)

Chair of the Board

Dr. Brian Postl
Dean of Medicine, University of Manitoba
(Winnipeg, Manitoba)

Region 1—British Columbia and Yukon

Mr. Howard Waldner
Chief Executive Officer, Vancouver Island Health Authority
(Victoria, British Columbia)

Region 2—Prairies, Northwest Territories and Nunavut

Dr. Chris Eagle
Executive Vice President, Quality and Service Improvement,
Alberta Health Services
(Edmonton, Alberta)

Dr. Marlene Smadu
Associate Dean of Nursing, University of Saskatchewan
(Regina, Saskatchewan)

Region 3—Ontario

Mr. Saäd Rafi
Deputy Minister, Ministry of Health and Long-Term Care
(Toronto, Ontario)

Ms. Janet Davidson
President and CEO, Trillium Health Centre
(Toronto, Ontario)

Region 4—Quebec

Mr. Denis Lalumière
Assistant Deputy Minister, Strategic Planning, Evaluation and Quality,
ministère de la Santé et des Services sociaux
(Québec, Quebec)

Dr. Luc Boileau
President and Director General, Institut national de santé publique du Québec
(Québec, Quebec)

Region 5—Atlantic

Mr. Don Ferguson
Deputy Minister, Department of Health, Government of New Brunswick
(Fredericton, New Brunswick)

Mr. John McGarry
Private Health Administration Consultant
(Fredericton, New Brunswick)

Canada at Large

Dr. Marshall Dahl
Consultant Endocrinologist, Vancouver Hospital and Health Sciences Centre and Burnaby Hospital
(Vancouver, British Columbia)

Dr. Vivek Goel (Vice Chair)
President and CEO, Ontario Agency for Health Protection and Promotion
(Toronto, Ontario)

Chair, Canadian Population Health Initiative Council

Dr. Cordell Neudorf
Chief Medical Health Officer, Saskatoon Health Region
(Saskatoon, Saskatchewan)

Health Canada

Ms. Anne-Marie Robinson
Associate Deputy Minister of Health
(Ottawa, Ontario)

Statistics Canada

Mr. Wayne Smith
Chief Statistician
(Ottawa, Ontario)

The Board of Directors met in June, November and March.

Board of Directors Committee Membership

Human Resources Committee

The Human Resources Committee assists the Board in discharging its oversight responsibilities relating to compensation policies, executive compensation, senior management succession and other key human resources activities.

Members

Brian Postl (Chair)
Marshall Dahl
Vivek Goel
John McGarry
Marlene Smadu

The committee met in March.

Privacy and Data Protection Committee

The Privacy and Data Protection Committee reviews and makes recommendations on the direction of the privacy program, reviews the findings of the privacy audit program, formulates recommendations for our privacy and data protection practices based on audit reports and advises the Board on implications of significant developments in privacy legislation. This committee also receives reports of major incidents within CIHI that could be seen as constituting a breach of confidentiality and submits an annual report to the Board.

Members

Vivek Goel (Chair)
Denis Lalumière
Anne-Marie Robinson
Brian Postl (ex officio)

The committee met in November and March.

Governance Committee

The Governance Committee assists the Board in improving its functioning, structure, composition and infrastructure. This committee also exercises the powers and duties of the nominating committee, in accordance with our bylaw.

Members

Chris Eagle (Chair)
Luc Boileau
Cordell Neudorf
Wayne Smith
Brian Postl (ex officio)

The committee met in October and February.

Finance and Audit Committee

The Finance and Audit Committee reviews and recommends approval of the broad financial policies, including the yearly operational plans and budget, and reviews the financial position of the organization and our pension plan. This committee also formulates recommendations on the financial statements, the auditor's report and the appointment of the forthcoming year's auditors, and it provides direction and review of our internal audit program.

Members

John McGarry (Chair)
Janet Davidson
Don Ferguson
Howard Waldner
Brian Postl (ex officio)

The committee met in May, June, August, October, November and January.

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